



# We're Safe Here Now: Counseling victims of violence after terror



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## INTRODUCTION

The counseling trainee (counselor) and the clients described herein are native to the African continent. At the age of 12 the counselor volunteered at a refugee camp in Nairobi, Kenya where she witnessed atrocities. This experience inspired her to become an advocate for victims. The counselor graduated with a B.S. in Public Health from Southern Connecticut State University in 2010. She then worked as a program manager for a residential program for mentally ill individuals in this area.

### Victim of Terror

She returned to Africa in 2013 to visit family when she and her 1 year old son became victims of a terror attack at the Westgate Mall Nairobi, Kenya. They were captive in the mall with other victims (deceased and living) for four days. She thus had first hand experiences that connected her emotionally to victims of violence. This connection creates both empathy and challenge. The challenge is to cope with memories and feelings in the context of client sessions.

### Purpose of this Presentation

The purpose of this project was to two fold:

1. For the counselor and her peer to deeply explore the experience of a counseling trainee working with sexually victimized refugees in the context of the counselor's prior trauma.
2. To explain this exploration so that others would appreciate the issues involved.

### Client #1

Client is a mid 30s African single, unemployed female. She was born and raised in West Africa and came to America 6 months ago as a refugee along with her teen child. They share a house with other family members. Client speaks some English but the counselor was able to speak with her in a common language. Client friend came with a client for assistance as client reports and appeared to have physical issues. Client presented with depressed mood and flat affect. Client reports has been experiencing nightmares and flashbacks of a life threatening event where her many children, husband and her parents were killed during war several years ago for the last 6 months. Client reports avoiding crowds and situations that remind her of the past and feeling unsafe, lack trust and continue to experience negative memories for the last 6 months. Client reported "I cannot remember anything" has serious difficulty concentrating, remembering or making decisions, difficulty walking or climbing stairs, difficulty with self-care (dressing and bathing), difficulties in maintaining activities of daily functioning (attending scheduled doctors' appointments) Client is not oriented to person time and place. Client reported being diagnosed with HIV 6 months ago in Africa and reports experiencing physical, emotional, sexual abuse during war.



**Counselor and her baby accompanied by her brother,**  
**September, 2013.**

## DISCUSSION

The counselor has been treating Clients 1 and 2 for many weeks now. In the beginning, she found herself more in need of support due to feeling "drained" after the sessions. She dealt with this emotional arousal by seeking supervisor support at the agency and family support at home. Both clients have improved since beginning counseling but both still face enormous emotional and social challenges.

Self doubt is a normal part of counselor training that can be magnified when client issues are similar to trainee issues. This counselor trainee has deeply considered whether she should be counseling victims of violence. She asks how she can help others when she herself has needed help. She has discussed these concerns openly with supervisors and program faculty. The consensus has been that as long as there is supervision and there are safeguards to protect the trainee and the client this counselor has much to offer her clients.

This counselor has many strengths that make her highly qualified to treat Clients 1 and 2 and others like them. She is multilingual and can communicate in their native language. She is also bi-cultural. The same counselor life experiences that may pose risks may also be strengths. Knowledge is both cognitive and emotional. This counselor understands trauma and the African immigrant experience cognitively through the knowledge of facts and emotionally through the experience of feelings. In that sense, counselors who have survived trauma may have knowledge that only the trauma experience can impart.

Vicarious trauma occurs when clinicians are repeatedly exposed to trauma victims' stories. This is a serious health threat for clinicians that training programs and supervisors should seek to ameliorate. Counselors who are themselves already survivors of trauma are at greater risk for vicarious traumatization<sup>3</sup>. Symptoms of vicarious trauma in clinicians are numbing, irritability, denial and "victim blaming." It is important that trainees take responsibility for their own health and well-being. The counselor-trainee described herein practices the following preventative measures:

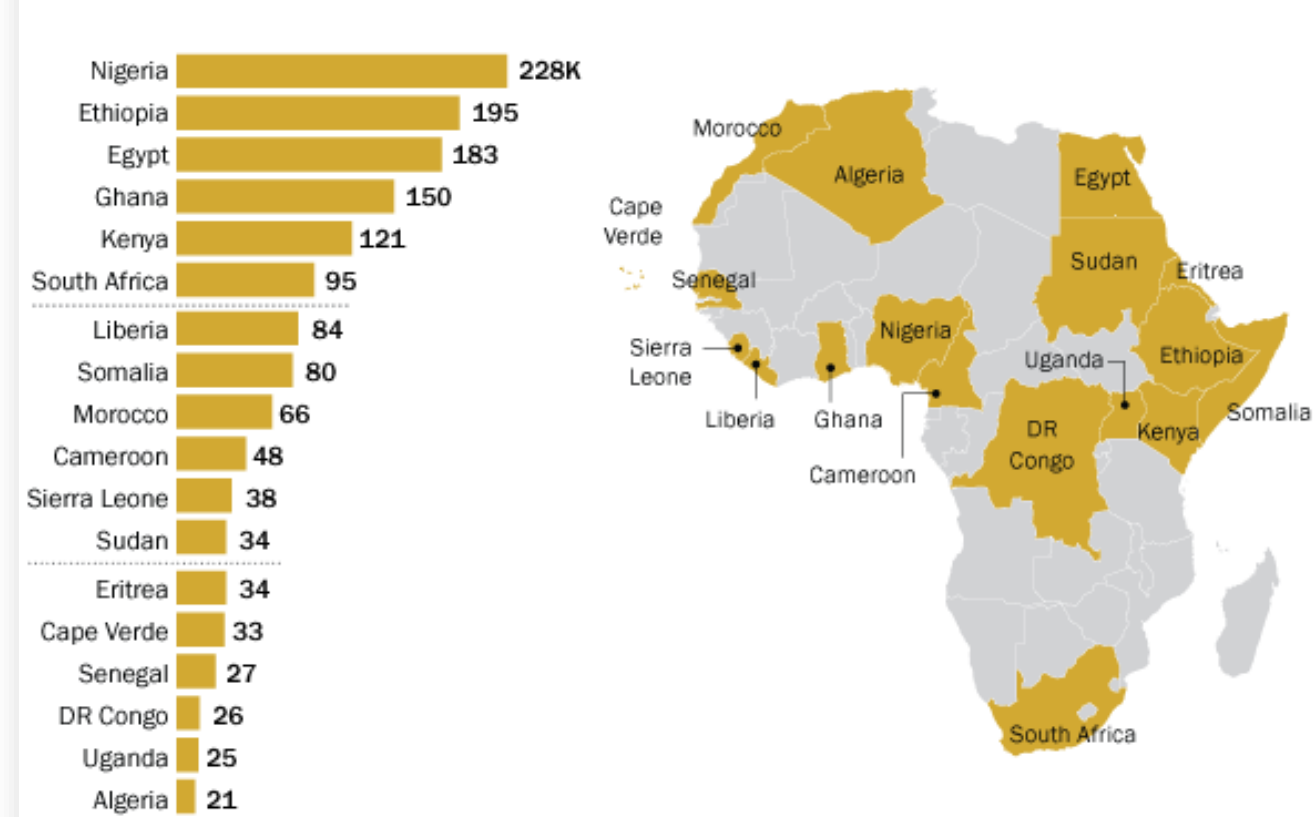
1. Consultation with supervisors and faculty
2. Personal therapy
3. Healthy lifestyle practices (diet, exercise)
4. Focused time with spouse
5. Focused time with child
6. Focused time with G-d
7. Breathing exercises
8. Time off

## REFERENCES

1. Experiences of Refugee Women and Girls from the Democratic Republic of Congo — EthnoMed.  
<http://ethnomed.org/culture/other-groups/congolese/IRC%20Backgrounder%20on%20Congolese%20Women%20and%20Girls.pdf/view>
2. World Health Organization, Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence (2013)  
[http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf).
3. Stamm, B. (1995). Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators. The Sidran Press.

### Nigeria, Ethiopia, Egypt Are Top Birthplaces for African Immigrants in U.S.

Leading countries of origin for the foreign-born African population in the U.S. (2013, in thousands)



Note: Africa includes North African and sub-Saharan African countries as defined by IPUMS.  
 Source: Pew Research Center tabulations of the 2013 American Community Survey (1% IPUMS)

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### Scope of the Problem

Nairobi, Kenya is 7,350 miles from New York, NY; yet many refugees are coming here due to the violence that has plagued much of Africa. Many of the women refugees have been traumatized by sexual assault as well as the violence they have witnessed. 25% or more have PTSD<sup>1</sup>. In addition to the risks posed by strangers, 30% of women worldwide are victims of intimate partner violence. Intimate partner violence is actually the most prevalent type of violence against women. The WHO estimates that 38% of all women murdered are killed by their intimate partner, although recognizes this is likely an underestimation. It also reports that 42% of women who had been sexually or physically abused by their partner were injured<sup>2</sup>.

### Client #2

The client is seeking services to help reduce symptoms of anxiety, sadness, and depression. The client is from Africa and came to CT to go to college. The client is currently living in a rented room and is seeking agency services to help plead her case for continued citizenship so that can go back to school. The client was in DV relationship in Oklahoma, was unable to attend college and was kept isolated from all friends and family. The client made her way to CT to acquire a new visa or citizenship and to leave DV relationship she had with her husband. She experienced sexual, physical, and emotional abuse by her husband. Client states she has a very limited support system and has not contacted her family since she originally came to CT over a year ago. Clinician recommendation: The client would benefit from 1:1 individual sessions to work on processing the DV relationship and learn new coping skills. The client has little to no support here in CT. She has very little income and is in need of finding a new place to live.